year to which such records relate.

(6) Department audit staff may perform a desk review of cost statements or reports and may conduct on-site audits of provider records. Such audits will be conducted in accordance with audit procedures developed by the department.

(a) Department audit staff may determine adjustments to cost reports or reported costs through desk review or audit of cost reports. Department audit staff may conduct a desk review of a cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) Department audit staff may conduct on-site audits of a provider's records, information and documentation to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.

(c) The department shall notify the provider of any adverse determination resulting from a desk review or audit of a cost report and the basis for such determination. Failure of the department to complete a desk review or audit within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

(d) The department, in accordance with the provisions of ARM 37.40.347, may collect any overpayment and will reimburse a provider for any underpayment identified through desk review or audit.

(e) For providers receiving per diem rates determined in accordance with ARM 37.40.313 and 37.40.314, if based upon desk review or audit of the provider's base period cost information used to determine the per diem rate, the department adjusts such costs upward or downward, the department shall adjust rates retroactively for the period of the per diem rate in accordance with adjusted costs and shall use adjusted cost information in any subsequent calculations for which such base period cost information is used. The provider shall not be entitled to any adjustment until the department has mailed notice of final settlement to the provider. Any overpayment or underpayment shall be paid or collected in accordance with the cost settlement procedures in ARM 37.40.347.

(7) A provider aggrieved by an adverse department action may request administrative review and a fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 2000 MAR p. 492, Eff. 2/11/00; TRANS & AMD, from SRS, 2000 MAR p. 1653,

Eff. 6/30/00.)

37.40.347 COST SETTLEMENT PROCEDURES (1) The department will notify the provider of any overpayment discovered. The provider may contact the department to seek an agreement providing for repayment of the full overpayment within 60 days of mailing of the overpayment notice.

(2) Unless, within 30 days of mailing of overpayment notice to the provider, the provider enters into an agreement with the department which provides for full repayment within 60 days of mailing of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete full recovery as soon as possible.

(3) The department may recover the full overpayment amount regardless of whether the provider disputes the department's determination of the overpayment in whole or in part. A request for administrative review or fair hearing does not entitle a provider to delay repayment of any overpayment determined by the department.

(4) The department will notify the provider of any underpayment discovered. In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of the amount of the underpayment.

(5) Court or administrative proceedings for collection of overpayment or underpayment must be commenced within 5 years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.

(6) The amount of any overpayment constitutes a debt due the department as of the date the department mails notice of overpayment to the provider. The department may recover the overpayment from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489.)

Rules 48 through 50 reserved

37.40.351 THIRD PARTY PAYMENTS AND PAYMENT IN FULL

(1) Regardless of any other provision of these rules, a provider may not bill the medicaid program for any patient day, item, service or other amount which could have been or could be paid by any other payer, including but not limited to a private

or governmental insurer, or medicare, regardless of whether the facility participates in such coverage or program. If the department finds that medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with ARM 37.40.347.

(a) This rule does not apply to payment sources which by law are made secondary to medicaid.

(2) The payments allowed under ARM 37.40.307 constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill or collect any amount from a medicaid recipient, other than the resident's patient contribution and any items billable to residents under ARM 37.40.331.

(3) This rule applies in addition to ARM 37.85.415. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.352 UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each medicaid resident in an intermediate care facility for the mentally retarded. 42 CFR 456 subpart F contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997). A copy of these regulations may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 53 through 59 reserved

37.40.360 LIEN AND ESTATE RECOVERY FUNDS FOR ONE-TIME EXPENDITURES (1) A one-time appropriation by the 2001 Montana legislature allowed the department to allocate funds from its lien and estate recovery program to the medicaid nursing home program. By the terms of the appropriation, the funds must be used for one-time expenditures to improve the quality of life for residents and/or staff in nursing facilities.

(2) The department will allocate to each certified nursing facility located within the state of Montana its pro rata share

of the total appropriated funds, computed as provided in (3), which submits a qualifying request which is approved by the department. The funds are subject to availability and are a one-time appropriation to the nursing home program to be used only for one-time expenditures to improve the quality of life for residents and/or staff in nursing facilities.

(3) The department shall distribute the funds on the basis of medicaid utilization at each nursing care facility. The amount payable to each facility shall be the pro rata share of total available appropriated funds available based upon collections prior to the end of the state fiscal year ending June 30, 2000 and in subsequent fiscal years. The amount of funds distributed and payable to each facility shall be computed by dividing the total amount of funds available by the total number of medicaid days occupied in the fiscal year for all facilities, to arrive at a per medicaid day amount. Each facility's share will be calculated by multiplying the facility's number of occupied medicaid days for that period by the per day medicaid amount.

(4) To receive funds under this rule, a nursing care facility shall submit, and have approved, a request form to the department, which specifies how the facility will use these funds for one-time expenditures to improve the quality of life for residents or staff in nursing facilities or both. The department will review each request and approve qualifying requests prior to making payment. If the cost of a proposal approved by the department exceeds the amount of funds payable to that facility, the department shall not be obligated to and will not reimburse the facility any more than its pro rata share of the available funding.

(5) Facilities that do not submit a qualifying request by the deadline established by the department, shall have their pro rata share of the funds distributed to all other facilities that have submitted a qualifying and approved request for these funds.

(6) A facility that receives funds under this rule shall maintain appropriate records documenting the expenditure of the funds. The documentation shall be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable medicaid record requirements, including but not limited to ARM 37.40.345, 37.40.346 and 37.85.414.

(7) The funds distributed under this rule are for one-time expenditures; and facilities will be required to offset these expenditures with the revenue received only under this rule on their annual cost report to the department. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS,

from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.361 ADDITIONAL PAYMENTS FOR DIRECT CARE WAGE AND BENEFITS INCREASES (1) Effective for the period July 1, 2001 and thereafter, nursing facilities must report to the department entry level and average hourly wage and benefit rates paid for direct care workers. The reported data shall be used by the department for the purpose of comparing rates of pay for comparable services. There will be no separate per day add-on computed for direct care wages after June 30, 2001.

(2) A one-time appropriation by the 1999 Montana legislature authorized the department to distribute to facilities an additional amount for wage and benefits increases for direct care workers in nursing homes for fiscal years 2000 and 2001.

(3) The department will pay medicaid certified nursing care facilities located in Montana who submit an approved request to the department, an additional amount, computed as provided in (4), as an add-on to their computed medicaid payment rate to be used only for wage and benefit increases for direct care workers in nursing homes.

(4) The department will determine a per day add-on payment, commencing July 1, 1999 and at the beginning of state fiscal year 2001, as a pro rata share of appropriated funds allocated for increases in direct care wages and benefits.

(5) To receive the direct care add-on, a nursing facility shall submit for approval a request form to the department which indicates how the direct care add-on will be spent in the facility. The facility shall submit all of the information required on a form to be developed by the department in order to continue to receive the additional add-on amount for the entire rate year. The form will request information including but not limited to, the number of FTE's employed by category of authorized direct care worker that will receive the benefit of the increased funds, current per hour rate of pay with benefits for each category of worker, projected per hour rate of pay with benefits after the direct wage increase has been implemented, number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit, and number of projected hours to be worked in the budget period.

(6) A facility that does not submit a qualifying request for use of the funds distributed under this rule which includes all of the information that is requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds. The department shall make retroactive adjustment to the payment rate

established on July 1, 1999 and in state fiscal year 2001, which will reduce the medicaid per day payment amount by the amount of funds that have been designated for the direct care wage add-on for any non-participating or non-qualifying facility. Any amounts paid by the department up to that time for the direct care wage add-on shall be recovered by the department.

(7) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable medicaid record requirements, including but not limited to ARM 37.40.345, 37.40.346 and 37.85.414. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.5.310 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS FOR MEDICAL ASSISTANCE PROVIDERS (1) The following administrative review and fair hearing process applies to all medical assistance providers that are aggrieved by an adverse action of the department, except medical assistance providers appealing eligibility determinations as a real party in interest.

(2) A medical assistance provider, other than a medical assistance provider appealing an eligibility determination as a real party in interest, aggrieved by an adverse action of the department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the department to consider in the administrative review. The request must be mailed or delivered to the Department of Public Health and Human Services, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and should be addressed or directed to the division of the department that issued the contested determination. The request for administrative review must be received by the department within 30 days of mailing of the department's written determination.

(a) Within the 30 days a provider may request in writing an extension of up to 15 days for submission of a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the department within the period of any previous extension, and must demonstrate good cause for the extension.

(b) The provider may also request a conference as part of the administrative review. If the provider requests an

administrative review conference, the conference must be held at a time scheduled by the department as provided in ARM 37.5.318(3) through (3)(c)(ii). If a provider requests a conference as part of the administrative review, any substantiating materials the provider wishes the department to consider as part of the review may be submitted no later than the time of the conference. The conference may be conducted by the department or its designee and shall be based on the department's records and determination and the provider's written objections and substantiating materials, if any.

(c) No later than 60 days following receipt of the written objections and substantiating materials, if any, or the conference, whichever is later, the department must mail a written determination concerning the provider's objections and substantiating materials and the position the department takes concerning the determination.

(d) A provider must exhaust in a timely manner the administrative review process provided in this rule before requesting a fair hearing. A provider that has not exhausted the administrative review process, including a provider that fails to timely request an administrative review, is not entitled to a fair hearing before the department or the board.

(3) In the event the provider is aggrieved by an adverse department administrative review determination, the following fair hearing procedures will apply. In addition to the authority granted in ARM 37.5.313, the hearings officer may dismiss a fair hearing request if a provider fails to meet any of the requirements of (3)(a) through (3)(e).

(a) The written request for a fair hearing must be mailed or delivered to the Department of Public Health and Human Services, Quality Assurance Division, Office of Fair Hearings, P.O. Box 202953, Helena, MT 59620-2953.

(b) The request must be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of mailing of the department's written administrative review determination.

(d) The fair hearing request must contain a short and plain statement of each reason the provider contends the department's administrative review determination fails to comply with applicable law, regulations, rules or policies.

(e) The provider must serve a copy of the hearing request upon the department's division that issued the contested determination within 3 working days of filing the request. Service by mail is permitted.

(f) The hearings officer will conduct the fair hearing in accordance with the applicable provisions of this subchapter at

Helena, Montana. The hearing shall be in person except that the hearing may be conducted by telephone as mutually agreed by the parties.

(g) The hearings officer will render a written proposed decision within 90 calendar days of final submission of the matter to him.

(4) In the event the provider or department is aggrieved by a hearings officer's proposed decision, the provider or department may request review by the board of public assistance as provided in ARM 37.5.331.

(5) The provisions of this rule apply in addition to the other applicable provisions of this subchapter, except that the provisions of this rule shall control in the event of a conflict with the other provisions of this subchapter. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1992 MAR p. 1496, Eff. 7/17/92; AMD, 1993 MAR p. 3069, Eff. 1/1/94; AMD, 1994 MAR p. 1744, Eff. 7/1/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)